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HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 WEST JEFFERSON STREET, 2ND FLOOR, SPRINGFIELD, ILLINOIS 62761
LONG TERM CARE FACILITY ADVISORY SUBCOMMITTEE

MEETING

MAY 9, 2017

STATE OF ILLINOIS

HEALTH FACILITIES AND SERVICES REVIEW BOARD

LONG TERM CARE ADVISORY SUBCOMMITTEE

525 West Jefferson Street, 2nd Floor

Springfield, Illinois 62761

MEETING OF THE LONG TERM CARE ADVISORY SUBCOMMITTEE

The meeting of the Subcommittee was held by video and teleconference on May 9, 2017, scheduled to begin at 10:00 a.m.

MEMBERS PRESENT:

Michael Waxman (by telephone), Chairman

William Bell, Vice Chairman

Alan Gaffner, Member (by video)

Charles Foley, Member

Steven Lavenda (by video), Member

John Florina (by telephone), Member

Paul Corpstein, Member

Denise Norman (by video), Member

Gerry Jenich (by video), Member

ALSO PRESENT:

Juan Morado, Jr. (by video) - HFSRB General Counsel

Jeannie Mitchell (by video)- HFSRB Assistant General Counsel

George Roate - IDPH Staff

Michael Constantino - IDPH Staff

Courtney Avery (by telephone) - Administrator, HFSRB

Nelson Agbodo, HFSRB Staff

John Kniery (by telephone) - Foley & Associates

Court Reporter: Jennifer L. Crowe, CSR
Illinois CSR #084-003786
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CALL TO ORDER

1. Roll Call
2. Approval of Agenda
3. Approval of Minutes
4. Re-cap of Education Session Conference Call.
5. Framework for future Education Sessions
6. Presentation to HFSRB on Medicaid Funding
7. Other Business
8. Next Meeting Dates(s)
9. Adjournment

(Start time 10:11 a.m.)

MR. MORADO: I guess we can go ahead, get started. Mr. Waxman, because you are calling in, do you want me to assist with chairing the meeting today?

CHAIRMAN: Absolutely.

MR. MORADO: Okay. Great.

CHAIRMAN: You do a great job of assisting.

MR. MORADO: Thank you, sir.

CHAIRMAN: You do a great job in doing it, so go for it.

MR. MORADO: Thank you very much. All right. I guess we will call the meeting to order. We can do a roll call. If we can start in Springfield, please.

MR. CONSTANTINO: Mike Constantino, IDPH.

MR. CORPSTEIN: Paul Corpstein, IDPH.

MR. AGBODO: Nelson Agbodo, HFSRB.

MR. BELL: Bill Bell, Illinois Health Care Association.

MR. FOLEY: Charles Foley, Foley & Associates.

MR. MORADO: Here in Chicago? All right. Here in Chicago?

MR. LAVENDA: Steve Lavenda, Marcum.

MR. MORADO: Juan Morado, HFSRB.

MS. MITCHELL: Jeannie Mitchell, HFSRB.

MS. NORMAN: Denise Normal, Transitional Care Management.

MR. GAFFNER: Alan Gaffner, the Alden Network of Long-Term Care.

MR. MORADO: Finally on the phone, please?

CHAIRMAN: Mike Waxman.

MS. AVERY: Courtney Avery.

MR. MORADO: Okay. We have Mike Waxman.

MS. AVERY: HFSRB.

MR. MORADO: And I know we have John Florina and John Kniery; is that right? Anyone else?

(No response.)

MR. MORADO: Well, we do have a quorum and move forward, take action as necessary today.

The first thing on our agenda is the approval of the agenda. So if you want to take a look at it quickly, let me know if you have any changes, and I would entertain a motion to approve it at this time.

MR. FOLEY: So moved.

MR. GAFFNER: Second.

MR. MORADO: Okay. We have a moved by Mr. Bell; is that right?

MR. BELL: Mr. Foley.

MR. MORADO: Mr. Foley. Seconded by Mr. Gaffner. All those in favor?

(Ayes heard.)

MR. MORADO: Opposed?

(No response.)

MR. MORADO: All right. Ayes have it.

Moving forward, approval of the minutes. So what I have for you is the notes from our last meeting. In addition to that we had the minutes posted.

Are they posted on the web site yet, Mike, from the last meeting, do you know?

MR. CONSTANTINO: They should be, Juan. I will double-check.

(George Roate now present.)

MR. MORADO: You know, I didn't get a chance to print those out, and I'm not sure if folks have had an opportunity to read those yet. If you haven't, we can table this to the next meeting, or if we feel comfortable, I can entertain

a motion for the approval from the last meeting.

CHAIRMAN: Juan, a question. This is Mike.

MR. MORADO: Yes, sir?

CHAIRMAN: Do you, do you include as attending those who are on the phone?

MR. MORADO: Can you say that one more time?

CHAIRMAN: Do you include as attendees those of us that called in?

MR. MORADO: Yes, sir.

CHAIRMAN: Because I didn't see my name listed.

MR. MORADO: Oh, okay. Well, I will make sure we get that changed. I apologize.

CHAIRMAN: In cap letters would be fine. Thank you.

MS. MITCHELL: Bold, underlined.

MR. MORADO: We can do that, Mr. Chairman, not a problem.

CHAIRMAN: Bold and underlined, thank you.

MR. MORADO: All right.

CHAIRMAN: Do you have a court reporter?

MR. MORADO: We do have a court reporter today.

CHAIRMAN: I take back everything I said. Thank you.

MR. MORADO: All right. Well, you know, in that case, let's hold off on the approval of minutes until the next meeting. We can do that when we reconvene.

Moving onto no. 4 of the agenda, it is the recap of our conference call which we got a great turnout on that conference call. I want to thank folks for taking time out of their day to engage and to kind of get the ball rolling so that we have an idea what we are doing today and how we are going to be moving forward in general for the next couple of months.

The call itself I made, I wrote up some notes from it. I sent that in an email yesterday. It really highlights the different issues that we spoke about. First and foremost right now looks like we are still on for the June 20th meeting to have our educational session.

The meeting that we had, the conference call rather, was focused more on the issue of Medicaid funding and its effect on the long-term care community and how we want to educate the board

about those effects.

So we are going to go through basically the issues themselves quite a bit as we talk more about the presentation, but the notes you will see touch on the Medicaid funding issue. We confirmed the date of June 20th. The invitations to General Assembly staffers to come to our meetings are going to be going out. So they will be aware that we are going to be having these discussions. We are also going to send copies of our presentation to them after it is made on June 20th so they have it.

There was some homework that was needed to get done by the folks here. Steve sent around some notes and got his information done. So I thank you very much for putting that together.

MR. LAVENDA: Not a problem.

MR. MORADO: I was supposed to do a couple things. I got those items taken care of, I think.

Alan, do you have some information for us when we get into the presentation later?

MR. GAFFNER: (Nods head.)

MR. MORADO: Thank you. We don't have Kelly Cunningham on the phone, so I'm not sure if she had a chance to put together information about

the HFS certification process for us, but I can follow-up with her.

Finally, the, kind of link this into our next bullet point on the agenda is we talked about an opening statement for that June 20th meeting, and the opening statement would be kind of our, our, a little bit more comprehensive where we would have a chance to lay out the different, different issues we would like to present education sessions on for the board.

So some of the items that we brought up, and you will see them in the notes, are obviously the Medicaid funding issue which is going to be the first one. In addition to the Medicaid funding issue, we thought assisted living facilities was something that we wanted to talk about. And as I have come to find out, because I did have an opportunity to reach out to Lynda Cavorek (phonetic). Thank you, Paul, for that contact. I appreciate it.

First you should also note that the way I spelled her name on the notes is completely wrong. Yeah. So it is Lynda with a Y, not an I, and Cavorek is spelled completely different. So as

soon as I figured that out, I was able to get in contact with her, but what I found out from Lynda is that she, in fact, deals with what she termed as assisted living facilities but that she doesn't have jurisdiction, I guess, over supported living facilities which is a program that's run out of HFS. She gave me another individual that I could talk to about that, but she did, in fact, tell me how many facilities she licensed, how many establishments, and I think, Paul, you may have mentioned before that they don't look at it as a per bed kind of thing, it is based on a unit.

MR. CORPSTEIN: Right, correct. They do units, but what that actually means I couldn't actually tell you, though.

MR. MORADO: Right. So what I can tell you guys is that they license today 422 different establishments for a total of 20,005 units.

Now, here is the tricky part. Two people can share a unit, and they really have no way of telling us whether or not two people are sharing one or all of those 20,000 units today. But she did, she did say she was open to coming to a meeting in the future. She was not able to make it

today, but if we wanted to have her come in, speak a little bit more about what it is that her group does and assisted living facilities that are under her jurisdiction, she would be happy to.

Over at HFS, Kara Helton, she oversees the state licensure for private pay assisted living or, sorry, supported living facilities because they get the Medicaid money that runs through HFS. And assisted living facilities are private pay. There is no federal oversight which is why it stays under DPH, and they have no jurisdiction over the supported living. So that was one.

MR. FLORINA: Juan, this is John Florina. I didn't want to have to revisit the issue, but since we are talking about the number of establishments and units, is it possible to also find out how many applications are in process that aren't included in these different establishments of 422?

I'm just trying to somehow ascertain how the growth of this segment of the continuum is occurring, and I think it would be very helpful because I'm seeing AL facilities popping up in every town in my area.

MR. MORADO: I would be happy to ask, and perhaps they may have some historical data on that, how many facilities have been licensed over maybe we will look at the last ten years so we have a snapshot. But yeah John, I would be happy to ask that information from Lynda with a Y.

MR. FLORINA: That, yeah, that would be a baseline where we start from, would really be helpful how it's impacted our planning process.

MR. MORADO: Right. Yep. I can do that for sure.

MR. KNIERY: This is John Kniery. If I can make one comment. I believe Mike Constantino has done this before, but I think over the last eight, eight years, ten years we have lost about 20,000 beds out of nursing home inventory.

MR. MORADO: Okay. All right. So we will see, we will see how many beds were lost if we can ascertain that.

MR. CORPSTEIN: I don't know if I can go back 20 years, but I have give a solid 10 or 15 years maybe total. I don't know about 20. I wouldn't trust the numbers really.

MR. MORADO: I think that would be

sufficient, Paul. I appreciate that. If that's something that you can pull, that would be great. And then I will find out about applications in the pipeline, try to get us some historical data over ten years on assisted living facilities.

So that was one of the sections that we thought would be its own kind of education session, assisted living facilities. There was three different, two different prongs, I guess, underneath that; memory care facilities and then supported living facilities.

Is there anything else that from, that should be included in that conversation or are there two items under that heading good enough? Thoughts?

MR. BELL: The only other one you might consider is sheltered care which is similar to assisted living but it is under the Nursing Home Care Act.

So you have got assisted living which is under its own act, you have got supportive living which is under a waiver program with HFS, then you have got sheltered care which is similar but it is under the Nursing Home Care Act. All three of them

are similar.

MR. FOLEY: Also have home health care, but I don't know how you are going to count that in.

MR. MORADO: So, I mean, that conversation, then, if we make it something a little more general, is it about alternatives to long-term, traditional long-term care facilities? Is that kind of the heading? And then all these different subsections, sheltered care, assisted living, supported living and home health care?

Do we want to maybe, when we present to the board, what's the purpose of presenting right?

Are we going to go to the board and say these are some of the other alternatives to traditional long-term care facilities, and these are the effects those facilities are having on us?

What do members foresee as the presentation being about?

MR. FOLEY: Good question.

MR. FLORINA: This is Florina. I will throw in a thought there. To me it is putting a perspective on the changing environment for the provision of long-term care services within the continuum, and if we have outliers, we don't count

these third types of providers, we can't complete an accurate bed need to meet the needs of the systems.

MR. MORADO: Okay.

CHAIRMAN: This is Mike. I think based upon, you know, watching and listening to the original meeting, it is pretty clear to me that most of the mother board members really don't understand the long-term care marketplace. Not only are they thinking probably narrowly about a nursing home, but I don't think they have a complete understanding of what the competition for nursing homes comprise.

So it is, I think it is an education that represents the nursing home industry but oftentimes competition from assisted living, sheltered and all those other things, just define it so that, again, when they are talking about making decisions on bed need, we don't know bed needs, we don't know bed count.

So I think it is a broad education of understanding what really is representing the long-term care marketplace in Illinois.

MR. MORADO: Okay.

MR. FOLEY: How do we fix it?

MR. MORADO: You know, under, just from the first few things that I heard right now, the idea of a changing environment and the common thread I think in both those comments, John and Mike, was how these facilities affect our ability to have an accurate bed count. I like the idea of, Mr. Chairman, about an education on what the marketplace looks like.

I think to be most effective what we want to do is try to, one, educate them just generally about what is going on in the marketplace. That's why I like that idea. But two, try to make a point, right, and our point is that this is going, this affects our planning process because we are unable to say that, you know, we are unable to look at an accurate bed count or get an accurate need reading for a particular community.

So, again, as Mr. Foley said, what, how do we fix that, right?

MR. FOLEY: Yes.

MR. MORADO: I'm not, I am not going to pretend to know the answer to that question, but I would be very welcomed to hearing anybody's ideas

about what some possible suggestions we can make to the board would be on this, on this particular, how we account for these types of facilities.

MR. GAFFNER: That is a question that is that next step part and most difficult, I believe, maybe in the short term until we have had some deliberation on it, but there is a whole continuum there from do nothing to what we have mentioned a time or two in our meetings which is license AL facilities and beds, have them be a part of a CON planning process just as long-term care facilities are.

John makes a good point that they are, even downstate, assisted living facilities are sprouting like mushrooms. That would seem to fit the aging of baby boomers, yet I think we'd be naive to believe that it has not impacted long-term care census because that's certainly continuing to take a downward trend, and then you get into the whole issue of as I still hear providers talk about residents within the AL setting that likely should be in a long-term care facility but the family doesn't want them to move, the assisted living folks just try to stretch it out a little bit

longer and then it often hits a wall clinically where medically some condition escalates and they have to be moved.

So there is a, I see that as a whole continuum of very sensitive issues, but I believe we ought to talk about their impact and how we educate the planning board on that.

MR. MORADO: Can I ask, the associations that you different members represent individually, are these facilities part of these associations, or do they have their own association?

MR. GAFFNER: They have their own. They have their own.

MR. MORADO: And are the assisted living facilities associations separate from the supported living, or do they kind of get together everybody that's not a traditional long-term care?

MR. GAFFNER: They have that commonalty.

MR. MORADO: Okay.

MR. GAFFNER: Doesn't mean that some long-term care providers may have some AL and SL, but they have their own stand-alone association.

MR. MORADO: Yes, John?

MR. FLORINA: This is Florina. Some of the

associations do have their own arm that deals with other types of providers. I know Illinois Health Care has an assisted living contingency with its own representation on the board. They also have developmental disabilities, skilled peds. So some of them are represented in more than one official association perspective, but my main comment was I wanted to confer with Alan that I think the first step is identifying the fact that there are other types of providers that are impacting the whole continuum of services.

So what the answers are is really the second step. It would be nice to have that resolved, but it appears many of the discussions that have occurred over the last number of years are not even acknowledging the fact that our whole bed need methodology is being impacted by things that we don't control at this point that are within the continuum of care.

So I would concur yes, it would be nice to get to that second step, but first we have to realize and accept the fact that there are things affecting us that we are not taking into consideration.

MR. MORADO: Really quickly for the benefit of the court reporter, Gerry Jenich has joined us here in Chicago.

(Gerry Jenich now present.)

MR. MORADO: All right. So my thoughts, unless people completely disagree, I would like to, I guess, retitle this discussion, this educational session. I don't know if we want to call it alternatives to traditional long-term care or maybe we call it the marketplace of long-term care, something like that, something along those lines.

MR. GAFFNER: Something of the latter. I think in terms of alternatives, there really are two very distinctly different levels of care, and in many families' minds, Juan, that's a great point that you really did just coincidentally, families view that as the alternative to long-term care or the phrase nursing home.

MR. MORADO: Right.

MR. GAFFNER: When it is really not. And that creates some of this disconnect that results, however, in the real world of decreasing long-term care census levels.

MR. MORADO: So do we call -- well, then,

maybe it is a summary of the long-term care marketplace, something like that.

MR. GAFFNER: That hits it.

MR. MORADO: All right. So that's what we are going to call it, and then maybe we can circle back in a second and figure out where it should fit in terms of the order of presentation to the board on that.

We discussed bed need methodology, and I feel like this is something that probably touches on almost every other thing we are going to talk about, right? The next three items really do. So I don't know how we break them up, if we break them up or if it is just one big mamma jamma, for the court reporter's benefit.

So, you know, under bed need methodology, I have listed under our notes last time the issue of dead beds, variance beds, assisted living beds and supported living beds.

Now, even in our short conversation right now talking about the, what is now termed the summary of long-term care marketplace, it sounds like we are going to be touching on bed need and how not, one, after educating them about what the

marketplace looks like, two, the effects of that marketplace and how it is making it difficult for us to have an accurate bed need.

So maybe it makes sense that we kind of, I guess, not stop the conversation but just don't get as in-depth during that one, and then we follow-up with something a little more robust on bed need methodology.

Just really quickly, the other two items we had was the 90% occupancy rule which actually probably could be something separate, but the buy/sell program, I think, also fits into bed need methodology, but the question, I guess, would be do we also break that out into its own. I mean, we probably could.

So all right. Let's talk about bed need methodology. There is those four items that are listed there. What's missing? Anything missing? How do we flush that conversation out?

Yeah, just generally right now what else would be missing, because we will have our own individual meetings on each of these before we actually do the presentation. The purpose of this exercise is just to have our outline, if you will,

for an opening statement to let the board know what road we are going to be going down.

MR. LAVENDA: Like a demographic study, I mean, where are you going to get the data from as far as the population would need this type of service?

MR. MORADO: Who would need long-term care? I'm not sure --

MR. LAVENDA: Yeah, I mean who -- is there data available to support the type of the formula that you come up with?

MR. MORADO: Nelson, is that something that maybe you can speak to a little bit?

Steve is asking if there is a source of data that we would use during our presentation to show the number of an aging population in a particular health service area for example.

MS. AGBODO: Yes, we do use the Census Bureau data to project for population that data that we use in the formula, and so when we do projection, we need population data. So, you know, population counts and death data that we get from IDPH, and we also use, you know, when we use death and population data, we actually project, we

calculate the life table and we derive some of the variable from the life table to project for the population. So that's what we use in our formula. The other part of the formula also use the census or the data that we collect every year on bed utilization.

So basically you have population data and you have bed utilization date that come together to produce the bed need that we publish. So if you need -- I think we, you know, the presentation that I give before cover, you know, all of the data that we need and how we do, we calculate the bed needs, and maybe if we go back to that presentation, we can find specifically information that you might use in your presentation, and I can definitely summarize what we did before so you can use that in your presentation. I don't know if that specifically what is needed, but again, the source of data that we use, Census Bureau and IDPH vital records data, those are sources we use for projections.

MR. MORADO: Mr. Foley?

MR. FOLEY: You know, Mr. Chairman, Juan, I think one important question we need to really and

truly look at and that is are the health care needs of our patients really and truly being met in these alternative settings.

That has, that has seemed to always bother me since, as we talked previously, we hear these horror stories about skilled nursing patients being in these other settings who medical needs may not, may not be met. I don't know whether that's true or not, but I think that's an issue that we really have to look at, whether they are in assisted living, supported living, shelter care or even if they are at home. We need to take a serious look at this and see if anything can be done. I don't know. There was --

MR. MORADO: I -- no, please go ahead.

MR. FOLEY: I was going to say there was talk a long time ago about maybe creating a assisted living environment that could be licensed as skilled and have what is called a floating license. That had been discussed in the past. It seems like as I'm hearing this discussion, families out there like the environment of assisted living facility with the one bedroom apartment. You cannot, you cannot get that license under present

day licensure standards because I believe, between Paul and Bill, correct me if I am wrong, I believe licensure standards state that the resident's bedroom must be visible from the nurses' station.

MR. CORPSTEIN: That's correct.

MR. FOLEY: If you have an inside bedroom that is, you know, separate from a living room door going into the hallway, you know, that is not visible by the nurses station. So that cannot be done. But then question comes up, can we change our licensure standards. That's a whole new entirely different subject. I don't know.

Other states, other states have what is called a floating license whereby if you have a, a say an assisted living facility where all beds would be under a skilled license and the patients would not have to be moved. So that was discussed.

So I don't know what the answer is out there, but I think just by looking at bed need methodologies and looking at the possibility of bringing all these other alternative measures under CON reviews so we can hopefully get a more accurate bed need or bed count I should say, I don't know what else we can do.

CHAIRMAN: This is Mike. Isn't the issue of, I mean, isn't the purpose of a CCRC is to take care of those residents that want the ability to be assisted living and have skilled beds available? Isn't that what that whole context is about?

MR. FOLEY: Yes, it is. Go ahead. Where you going with it, Mike?

CHAIRMAN: I was just thinking that rather than having to create something brand new, isn't it already in existence, or am I missing a point?

MR. FOLEY: Under the CCRC concept, if they file a CON under a CCRC variance, then admissions to that CCRC campus has to come from residents from their campus setting, but we have a lot of CCRC campuses out there that have been approved that is not a part of a, what do I want to say, defined population, and so they can admit anybody from anywhere, not just from within their campus setting. So it kind of skews the whole thing.

CHAIRMAN: The issue of whether people are -- I mean, I believe, I have always believed that people are in assisted living that need skilled services. I have been seeking that one for a long time. But isn't it that really a clinical point of

view or clinical issue? Isn't that beyond the scope of our committee to try to prove that unless we subcontract with nurses or something to go make that judgment?

MR. FOLEY: Well, you know, isn't there also, Bill and Paul, isn't there also a provision in the licensure rules that if you have in a particular setting more than three residents that are receiving nursing care, that that is, that could be considered a nursing facility and you have to get a license for that? Is that still correct?

MR. CORPSTEIN: The rule is you can care for less than three people that are not your relatives without a license.

MR. FOLEY: Less than three people who are not your relatives.

MR. CORPSTEIN: Right. You can do two of your relatives and two people that are not your relatives, and that would be not subject to having a license.

MR. FOLEY: Okay. What about these residents that are in assisted living facilities that are receiving skilled care?

MR. CORPSTEIN: Well, all I can say about

that is if anybody knows of a resident that needs skilled care that is in an assisted living facility, it is your responsibility to call that into the department. That's the part where Linda objects to this whole line of questioning is that they do regular inspections with nurses at those facilities, and that's one of the things they are looking for, residents that shouldn't be in an assisted living facility; that their condition requires that they need skilled care and that this is not the environment to be providing that kind of thing.

They regularly, I don't know how often they cite it and stuff, but if they find that kind of thing, the facility is cited and fined and what have you, and they have to transfer that resident.

I know it is -- you know, you can call up any anecdote and say well, that's the reason why. You know, the reason why is it used to be a nursing home was the only alternative. Sheltered care, intermediate and skilled, that was it. That's all there was.

MR. FOLEY: That's correct.

MR. CORPSTEIN: You guys got everybody.

Now there is many more options available. Like I said, my father-in-law went through multiple chemos and hospice and died, and he never once stepped foot in a nursing home at all. He did that all at home when you would think he was providing skilled care at home. A nurse came into the house every single day, did the things that she is supposed to do every single day. He never once went into a nursing home. Ten years ago that's the only way he would have been cared for was in a nursing home.

So we are overbedded. There is way more options. I don't necessarily believe that assisted living is rife with skilled patients and that's what is driving down occupancy. I think it is like so many things in this world this day is old industries are challenged by new industries that are different innovations, they have different rules and stuff.

I mean, who thought cab companies were going to be in trouble? You know, Uber comes along and boom, you know, upsets the pie. This is kind of the same kind of thing.

The board has been too generous in giving beds out over the last 20 years, 30 years or

whatever. The census is going down because you are no longer the only alternative. There are now many options. You know, in the past there was probably times where people were in nursing homes that actually didn't really need skilled care, there was just not any other option. You know, Grandma is going to leave the burners on, she is going to burn down the house, she can't, you know, she is forgetful, she is going to get in the car and not know where she is going, those kind of things.

So in the past you used to receive residents that weren't necessarily for skilled care. Now they are going to other facilities that are less restrictive or less, you know, less nursing care. You don't have, you know, a monopoly on those kind of residents anymore. They are overgenerous with beds giving out. There is less residents going around. You know, the industry has to, you know, recalibrate.

MR. FOLEY: Paul brings up some --

MR. CORPSTEIN: Downsize in some way.

MR. FOLEY: Paul brings up some excellent comments.

MR. CORPSTEIN: Mike needs to rent a van

and we need to go facility to facility and count those beds on the board's dime.

MS. MITCHELL: On the board's dime.

MR. GAFFNER: Paul, I want to agree with what you are saying about the market drives new concepts, and your cab versus an Uber service is a great example. I don't believe that I have ever talked to a long-term care provider that much like the horse and buggy didn't want the car to come along because it threatened their business. There is certainly a place for AL.

What I believe is the challenge that is difficult to find those residents is it is unknown where those residents in AL facilities are who may need long-term care, and they're remaining in that AL level because the long-term care provider doesn't know about it many times until they are moved to their facility. So it is hard to say within any given facility how many there are or there aren't.

I understand what the state does from a spot checking perspective. I believe that just as it is challenging to identify how many beds have been converted and no longer in use, it is also

somewhat difficult to know, what did we say, 20,000 units, I think it is difficult to know at any given day how many of those 20,000 units have residents that ought to be in a nursing home.

I'm not at all saying that it would suddenly fill every facility. Not at all. But I believe, as John indicates, and I'm right there with him, it has had a significant impact beyond just a change of delivery system.

MR. MORADO: You know, I think this entire part of the conversation brings up something really important that, you know, we, I think, need to recognize, and that is that, you know, the board themselves, although they may not be subject matter experts like many of you in this particular area, they are very smart people. Talking about a very intelligent group of folks, and I think they will realize that, you know, there is maybe a place for these AL facilities. And although part of our presentation is about educating them on long-term care generally -- can someone put their phone on mute, please? Thank you.

I guess what I'm trying to say, there is going to be opposition. Some of these ideas about

getting things under the jurisdiction of the board, it is going to be incredibly difficult to do that, but it is not a fight that we shy away from. I think I want to bring it back to what our goal is here and ultimately what our point is, right?

So we are making these presentations to the board to, one, inform them and, two, perhaps spur some recommendation from us to them to make some or seek some sort of whether it be legislative change, administrative rule change, whatever the case may be.

So maybe this section on the summary of the long-term care marketplace, and Chuck, I think some of the things that you mentioned will probably fit better under that conversation versus bed need. There is a couple that will probably fit under bed need but some better under the previous topic that we were talking about. Maybe some of the things that come out of that is hey, let's, let's really look at this idea of floating licenses or maybe let's, bless you, let's seek to get supportive living under the board's jurisdiction. If that's a recommendation we want to make and the board is charging us, Courtney, Jeannie, and I with, one,

drafting legislation and working with stakeholders to make it happen, then we will move forward in that way.

But I think our purpose here is to, you know, one, inform, and then, two, try to see if we can pull any recommendations that we want to make to the mother board about it. But just keep in mind that there is going to be opposition without a doubt.

I thank you, Paul, for your comments because it is sobering. You know, we are all kind of like-minded individuals here. We are working in the same industry, and there are certainly people out there who will disagree with this, but that doesn't mean that we should stop doing what we are doing. So I thank you for that.

MR. FLORINA: Now, this Florina again. Juan, I can't refute anything Paul said. I think he is on target with things from a market standpoint. I believe that evolution is important to make sure the board understands. If we don't recognize what's going on around us, it is kind of hard for us to do our responsibility here from a bed need standpoint dealing with skilled and NF

type services.

So I concur basically with what Paul said, but there is another aspect to it, and we have tried to address it in the other part of the presentation of the board. That's the effect that we are having, that it's having on facilities with Medicaid.

When you are laying out the beginning of this discussion, it is what does the marketplace look like, what is the state of the market and all these other factors that have an impact on it. I'm not sure we're at a point to suggest here is a specific thing we should do, but if we don't at least recognize that these things are going on, it is kind of hard to us to channel our energies, come up with some suggestions or some answers.

But one of the things that I think we can all agree on that's been developing is yes, there is alternatives to the traditional nursing home setting because the whole environment has evolved, but there is also a payment side to all of this that is also maybe it is tail wagging the dog with this, though, but there are people that are receiving services that can't afford to pay for

them in assisted living and others who can't and end up being in the long-term care nursing home setting, and that's where your Medicaid stuff is very important that Steve laid out.

We have been going down this road of a two-tier system, if I can make it that simplistic. We have got people that have money that have choices and it may not be the nursing home. Maybe it should be the nursing home, but they can afford not to be there. There is also others that don't have that option, and if they can't get in supportive living, they're going to be in the nursing home because that's where any services are available because there is not a Medicaid system to pay for assisted living.

So in the evolution of this whole process in this market, we have assisted living popping up on every corner, not to be too facetious about it, on every corner, and they're milking off patients that normally would have gone into the nursing home. I'm not debating that is a better place for them, all I'm saying is there is a payment function in this that does also affect where the patients are receiving their services.

MR. MORADO: Okay. I appreciate the comments, John. I'm going to move us on now because I think that we definitely know that bed need methodology is something that we want to touch on as a subject. When we get to flushing that out fully, I am expecting a very lively discussion. So we will circle back to that in the future.

We have two other items as far as topics go that I just want to touch on very quickly. The idea of 90% occupancy rule, I know, Gerry, that is something that you brought up, and it is an idea that maybe we should take a look at that, is that effective. We can -- again, this is another one we can flush out a little bit more as we bring it before the board for an educational session.

I would say that that falls under maybe a general heading of administrative rules. So I don't know if there is other administrative rules that folks think we want to include in that conversation that are either linked to the 90% occupancy rule or maybe just generally.

I don't know that the 90% occupancy conversation takes up a whole education session. Maybe it does. But if there is any other ideas in

terms of administrative rules that you want to bring up now that we can either include or make it its own topic, I would be welcome to hear them. Not all at once.

MR. GAFFNER: That's a good point. I had not thought in those terms. That's good.

MR. MORADO: Maybe for purpose of the opening statement we can say that we are going to do an education session on administrative rules and we will specifically say 90% occupancy and that will buy us some time to think if we want to add anything else.

MR. GAFFNER: I agree.

MR. MORADO: Finally I have buy/sell program as its own topic of discussion. So we will definitely make sure that we flush that out for our discussion with the board.

Are there any other topics that people think we need to be including or that we should bring before the board during one of these sessions? Yes, sir?

MR. FOLEY: Do we have any, how am I going to say this, do we have any jurisdiction on how a facility maybe should be built?

I mean, we are still seeing applications that are being built, applications being filed where a facility is still being designed as your traditional nursing home.

Can we look at licensure standards and see what modifications can be made there in order to present to our residents out there an alternative in nursing homes by creating a more home-like atmosphere, maybe not in total, total line of assisted living or supportive living facility but to get away from the traditional 8-foot wide 120-foot long corridor?

I know standards are being changed in terms of two beds versus private beds. We have got rid of three and four-bed wards, I know that, but is there anything else we can do with any facility structure itself that can create more of a home-like atmosphere?

MR. CORPSTEIN: Okay. I have a little bit on that. Clark-Lindsey Village which is on the corner or somewhere near the U of I campus. It was, it was coming out of California, I believe. It is trademarked process or system or whatever called Green Homes. We -- they just built a

20-bed, 20-bed, no, 12-bed, 12-bed facility across the campus street of the nursing home. It is an open plan. There is no nurses station. It is 12 beds around a kind of like dayroom/kitchen type activity area, not exactly sure. It is staffed with a CNA. They share DON and administrative between the buildings.

It did not meet life safety code for a couple of reasons, but one easy one is not viability from the nurses station because there is no nurses station. It went down to Henry's group, and they worked on it for, I don't know, a solid year or so. I recently licensed them like in the last month or so. Now --

MR. CONSTANTINO: We never approved those beds.

MR. CORPSTEIN: What?

MR. CONSTANTINO: We never approved those beds.

MR. CORPSTEIN: Are you sure?

MR. CONSTANTINO: Yeah.

MR. CORPSTEIN: I would have to look into that. I generally -- no, no, wait a minute, they got like four or whatever beds under the rule and

then moved eight from the facility to fill out this 12 or 20-bed facility. They only got a few and then drafted some from the rest of the facility. I will have to look at the record to be specific.

MR. FOLEY: You are saying they have --

MR. CORPSTEIN: It is a different plan of a building. It is only, I want to say it is only 12, but I may be wrong.

MR. FOLEY: Just one building for 12 beds?

MR. CORPSTEIN: Just one building for 12 beds around a kind of horseshoe, around a kind of day area, around that. There is no nurses station. It is called Green Homes, and it is like trademarked, all this kind of stuff. I was not involved in any of the waiver process. They absolutely had to receive some sort of waiver because they have not made any physical plant changes that you can just sign up for that right away, but that process, how they did that, I have no idea. That's out of my hands. It just comes up to me as approved, and we send out the nurses, and I cut the license.

MR. FOLEY: I guess my question --

MR. CORPSTEIN: He gives me beds.

MR. CONSTANTINO: We didn't give you beds.

MR. CORPSTEIN: Under the rule they got --

MR. CONSTANTINO: But they have to ask us for them.

MR. BELL: They could have done the 10% rule.

MR. CONSTANTINO: But they have to ask us for them, and we have never been notified of this. This is the first I'm hearing of this.

MR. CORPSTEIN: Well, let me go back.

MS. MITCHELL: We were notified, if I may, we were notified of this very early on when it was just an idea, but we have not been, there's been no discussion. We have not been updated since then. So I think Mike is somewhat correct that they didn't notify us and tell us they were going to add beds under our 10/20 rule.

MR. CORPSTEIN: I will look at the record.

MR. ROATE: If they moved to a different physical address, they --

MR. CORPSTEIN: That was part of the problem was that 911 and the city wanted to give that building a separate address, but I have no -- it is an impossibility for me to cut a license with

two addresses. They wanted it to fall under the -- they didn't want it licensed separately, different address, different license, all this kind of stuff because they are not, they don't have a separate DON, don't have a separate administrator, they are sharing them between the buildings. It is basically just an adjunct or add-on that is separated from the facility just like -- I mean, like let's say the veterans homes have multiple buildings.

MR. FOLEY: Two different --

MR. CORPSTEIN: Sorry?

MR. FOLEY: It is two different legal sites?

MR. CORPSTEIN: It is across an interior road on their campus.

MR. FOLEY: Oh, on their campus?

MR. CORPSTEIN: Like 150 feet away or 140 feet away, something like that, but the city or the county wanted us to give it a different address. We can't. We thought about it. I don't know, it was outside of my hands. This came down to being approved. I am going to go through the record. I'm going to find out. I don't generally make that

error anymore, so I'm going to make sure that is --

MR. CONSTANTINO: The last conversation, the last thing that I remember, Joe Orson's request asking us for approval of beds, and we told him we wouldn't do anything until licensure would give their approval.

MR. CORPSTEIN: Well, licensure gave their approval.

MS. MITCHELL: Then Courtney and I were -- right. And Courtney and I were on a call, again, very early on when this was just an idea and licensing was trying to figure out what to do because it couldn't be licensed under, you know, current life safety codes as you explained, Paul, but we were never updated as to what would happen and what has happened since then.

MR. CORPSTEIN: Okay.

MS. MITCHELL: Until now.

MR. CORPSTEIN: When I get back to my office I will go pull the record.

MR. CONSTANTINO: They will have a compliance issue I think here.

MR. CORPSTEIN: Not with me, with them.

MR. MORADO: Chuck, I think, I think what

we have --

MR. CORPSTEIN: There are models floating around I guess is my point.

MR. MORADO: There are other models. Thank you for the segue, Paul.

MR. CORPSTEIN: Sorry.

MR. MORADO: No, no, it is okay. Please. What I wanted to say, Chuck, was that I guess first and foremost I want to front this by saying we don't have jurisdiction over health care regulations of DPH obviously, but I think you bring up an excellent point, and I think it would be well received not only by the board but perhaps by the department if we can come up with an outline, whatever you want to call it, what we think an ideal nursing home should look like, and, you know, what the nursing home of the future, what kind of amenities, what type of building layout they should have. I think that's a great idea. I'm going to add that as one of our topics.

Anything else for topics, folks?

MR. GAFFNER: It might be something that we reference as we get into the form and substance on Medicaid, but I believe the planning board should

realize that there is somewhat of a vast unknown that does exist with federal health care reform and what will happen with their part of the Medicaid program and obviously as we have heard a lot coming out of Illinois just since the vote last Friday, what that might mean.

So I believe that they should understand that there is a great deal of uncertainty even though it has passed the house, but as far as Medicaid block grants that is basically going to create one pot of money that everybody has to go to and try to claw out is the phrase I use, their share or whether it looks like something different coming from the senate, but that certainly impacts the long-term care provider community in a significant way.

MR. MORADO: I couldn't agree more. I think that, that it would probably be its own, own education session. It may be that we are a bit on the early side of full flushed-out discussion and probably would warrant at best this point probably a mention that there is some uncertainty, but the idea of switching to a more of a block grant system for Medicaid funding is, it is a scary proposition

for many in long-term care and just health care generally.

So I think it might be prudent to hold off. Maybe that is something that we do include a little bit further down the line but certainly warrants mentioning. I mean, I don't know how anybody who is in health care is not aware of our just being worried about what --

MR. GAFFNER: You are right. There is so many, it would be difficult to do a substantive educational session because there is so much unknown, but I believe that they as the board should understand what a big part of the Illinois Medicaid long-term care program is, but it is kind of out there in space right now.

MR. MORADO: All right. So I have four, including Medicaid five different subjects that we will be having educational sessions on. If, for some reason, between now and meeting June 20th you think we should add something, let me know. It wouldn't hurt to add it into our opening statement then, I guess it might be --

MR. GAFFNER: I had one more.

MR. MORADO: Oh, yeah, please.

MR. GAFFNER: Staffing shortages.

MR. MORADO: Staffing shortages.

MR. GAFFNER: Just the inability to find, whether it be on the skilled RN side or even support staff to provide very important services that are needed.

MR. MORADO: Okay. Yeah, I think that would be a good topic. I feel like that would get the, something like that would get the attention of legislative leaders, the idea that there are jobs that need to be filled and we don't have people for them. There may be some sort of collaboration that can lead to hopefully connecting folks. I think that would be a great idea.

MR. GAFFNER: Thank you.

MR. MORADO: Okay. So we have got a bunch of topics. I think that's good.

Before we start digging into the presentation we are going to make on the 20th, can I ask who is going to be available to come on the 20th and who would like to present this?

Mr. Chairman, are you going to be free that day?

CHAIRMAN: Yes, I will make sure I am.

Thank you.

MR. MORADO: Thank you, sir. And then --

MS. MITCHELL: I would just recommend there aren't too many people at the table. I think, how many did we have last time, three? You know, conversation -- or four. The conversation continued on for much longer. I think the fewer people the more concise we can keep things. So that's my only recommendation.

MR. GAFFNER: Juan, I will be there, but I can either play no role or some role, but I do plan to attend on the 20th.

MR. MORADO: Okay. And then if anyone else is going to be attending on the 20th or interested, you guys can reach out to me directly. We can figure out what makes the most sense for the presentation that day.

I'm glad the chairman is going to be able to make it. I think that's a very good thing to have him out on front of this, and, again, we will start off with this general opening statement laying out our different subject areas, then we will start digging into the Medicaid presentation which brings us to no. 6 on our agenda today.

So, again, thank you to Steve and Alan, everyone else who did their homework and got us some information to go through. In addition to this, you know, one of my homework assignments was to reach out to Lynda with a Y. So I got some information from her which was good.

In addition, Jeannie and I had a very, very extensive educational session of our own with the medical director for HFS who incidentally is a ex officio member on the board.

So while we are giving this presentation on Medicaid and the issues and how it affects your industry, I can, I would be very confident that Dr. Goyal is going to have comments of his own, and he is very up to speed on a number of these issues.

So I just want people to keep that in the back of their mind as we are presenting and saying whatever it is we are going to be saying. You know, he is no lightweight, that's for sure.

I got to thank him for taking several hours out of his day the other day for Jeannie and I just to kind of give us a really in-depth look at Medicaid and how it works here in the State of Illinois. We are very grateful for that.

So with that said, Steve, I don't know if you want to talk a little bit about the information that you were able to put together for us. I sent that around in an email. I did print out copies for folks here in Chicago. It is in your email if you are able to pull it up now, and if you have it in front of you, we can kind of go through it

MR. LAVENDA: I mean, it is all pretty straightforward. I sort of laid out the history of when the state sort of deviated from what was in the administrative rules as far as it would take a cost report and then reimburse based on it a couple months later. That all kind of changed January 18th of 1994, and I gave you a history of the different changes that have happened since then.

And I also in this outline explained what the different components are, where they come from, and that was basically it.

MR. MORADO: Nelson, can I ask, would you be able to take the information, for example, in no. 2 of this handout and put it into a graph form so we would have something in addition to the text to show the board? Some people are more visual.

MS. MITCHELL: You mean a timeline?

MR. AGBODO: Okay. Yeah. Sure.

MR. MORADO: I'm thinking more of a grid than a timeline format. I'm thinking just something a little more visual to kind of show, you know, the peaks and valleys in terms of the rate itself increasing or not over a period of time.

MR. AGBODO: Okay. Yes.

MR. MORADO: Okay. I think that would be helpful.

MR. AGBODO: I will do that.

MR. JENICH: Steve, what are we trying to identify? Are we trying to --

MR. LAVENDA: I think most people just don't know what, you know, just trying to get some education.

MR. JENICH: Yeah, I think that's good, but, right, if I'm on the board I want to know, okay, and I mean this with all respect, right, so what. Are we trying to show that the net effect over the years in comparison to inflation? What are we trying to demonstrate?

MR. LAVENDA: That would be the logical next step to take it. Right now I was just laying out the history. Yeah, I don't know what the

dollars are involved. Like for some of it I can certainly find out, some of the older stuff probably not, but --

MR. JENICH: That's my question. What are we trying to --

MR. MORADO: What are we trying to accomplish?

MR. JENICH: Yeah.

MR. MORADO: I think, Gerry, to your point I'm not sure everyone else can hear what the question was. Gerry was asking Steve what, you know, what are we trying to accomplish with this information.

You know, the next bit of homework that was supposed to get done, Alan, was how does the Illinois rate compare nationally. I think this information combined with that can probably present a better picture of here is where Illinois sits, and, you know, probably going to be bad, but, you know, here is what the picture looks like nationally.

MR. LAVENDA: I think one thing that can come from this is the unpredictability of what a provider is going to get paid for providing a

service. You know, it is not necessarily if you spend and you spend more than your neighbor, you are not going to necessarily get anything back for it on top of, which this doesn't even mention, is the delay in payment that's been going on.

So you investing all this money in a business you don't know when your return is coming or if you are going -- not just return, but being paid enough to deliver the service.

MR. JENICH: To your point with staffing, right, the impact that staffing is going to have on, right, the calculations where we are not going to get compensated for the minimum wage increase, we are not going to get compensated for having to run extra staff or premium staff to cover shortages. That all factors into this picture which doesn't make it any better in the long run.

MS. MITCHELL: Good point.

MR. FLORINA: This is Florina. If I can make a suggestion. I think the bigger picture would be more impressive to anybody who is trying to be educated on this.

For example, Illinois, like all states, are ranked 1 through 50 as to their reimbursement rates

for Medicaid patients. That's primarily what we are talking about. And that would be a lot more visual impact to see that we are ranked, you know, like 49th and 50th out of the country and also if there is a graph, which is not hard to find, of costs versus reimbursement rates. So you can see how we are being underfunded every day to take care of the Medicaid patients.

MR. LAVENDA: I did something for that for 2006 and 2015. I didn't print it out, but I think for 2006, the amount per day under was like $84 a day and for 2015 it was down to about $66 a day.

MR. FLORINA: That would shock me if I didn't know anything about Medicaid.

MR. LAVENDA: You know, I would like to redo it leaving out the hospital based ones and some other outliers because I really think it is probably a lot less than those numbers, but I'm not 100% sure.

MR. MORADO: Is that something you feel comfortable with maybe for June 20th getting together?

MR. LAVENDA: Yeah, absolutely.

MR. MORADO: Okay.

MR. GAFFNER: I agree with John. If we can do some kind of a blending of either that graphing of showing the unpredictability, here is increase then here is a freeze and here is, throw in that 12.6% decrease, you know, in May and June of '15, but then when it gets to I think those two most shocking as I call them for lay members of the planning board is Illinois does still rank 49th. That's the latest information that the American Health Care Association uses as to where they place Illinois on the 50 state continuum.

And whatever that shortfall number is, Steve, whether it is 66 or if it is closer to $55 per day, I mean, people can imagine if they were trying to make their mortgage payment every month and they were $50 short, that doesn't last forever. There is a day of reckoning. So I think those would be very impacting.

MR. MORADO: Okay. All right. So I think that what we can do is we will take this information. This will certainly be included as part of the presentation. Nelson will try to work on maybe getting us some graphs out of this info. He may be bothering you a little bit, Steve, if he

needs a additional information.

MR. LAVENDA: I'm going to unlist my number.

MR. GAFFNER: Steve, is it possible -- and I think that's what you were saying, Gerry. Is it possible to indicate the overall cost increases in a percentage in the, let's say 10-year span or whatever you are influence is and state increases across the rate, because I'm sure it is going to be significantly different or we wouldn't end up with this $60 to $80 --

MR. LAVENDA: Yeah, disproportion.

MR. AGBODO: It is possible.

MR. GAFFNER: I'm just going to throw out arbitrary numbers. Costs have increased 25% while reimbursement has increased 9% overall.

MR. LAVENDA: I definitely can do that.

MR. MORADO: That sounds good. I think that would be helpful.

MR. FLORINA: Florina again. Couple detail items. If you are going to go into detail of listing the dates of rate changes and that, you might want to insert the beginning of the provider tax program so you can see what we are spending in

taxes to the government.

The second part, the second part is in your first bullet point to Medicaid reimbursement, I think you got the wrong department in there. You are saying IDPH. I think you mean HFS.

MR. LAVENDA: Yeah, probably came from an old handout.

MR. FLORINA: First bullet point and second, yeah, first bullet point and second bullet point. In order to get paid through HFS, you have to be certified, not just licensed.

MR. MORADO: Okay. Thank you, John.

MR. GAFFNER: That's a great point because many would not realize, again, a strange business model where the providers are paying that tax per bed to enable the State of Illinois to receive more money from the federal government but still it doesn't cover --

MR. MORADO: It is not covering everything, right.

MR. LAVENDA: The only reason they are still in business is through private pay and through Medicare.

MR. MORADO: So Alan, in terms of the rates

nationally, Illinois compares, I know we 49th.

Is there anything, I guess, handout wise or something more demonstrative we can use during this presentation?

MR. GAFFNER: Yes, sure. I can flush that out, I just was -- and I am sorry, I didn't --

MR. MORADO: No, that's fine.

MR. GAFFNER: But yes.

MR. MORADO: Excellent. You know, the next item that we wanted to talk about was the effect of the delay in payment. I think that's something that we can probably have, we can easily talk about with the board. One of the things we wanted to do was this idea of using a mock facility and the uncertainly, again, of reimbursement, the unpredictability and how, what a business actually has to go through to operate one of these types of facilities.

I think, Alan, you were going to reach out to see if anybody was willing to use one of their facilities as a blind kind of model, and in the alternative we were just going to make one up.

MR. GAFFNER: I don't have a facility yet. And I apologize in that my ability to try to

identify that was impacted a bit. Not long after our April 20th meeting is when a number of even our facilities received their intent to strike notice from SEIU. So those next three weeks were spent developing strike plans and working closely with IDPH. Now thankfully since that was at least a tentative agreement and I believe it will be worked on this week, I can go back, try to find a real life example one.

MR. MORADO: So great. We will have that. I think that would be good. I will follow-up with Kelly about the two-part process for certification, but I think that's, it is important, it is an important piece of this, right?

I mean, we are talking about delay in getting money, we are talking about the amount of money that gets in, but before even get to that point, you have got to get certified. Perhaps that is, that might be the front part of the discussion to lay background about the Medicaid program, how you get certified so you can, in fact, receive funding from Medicaid. Then we can kind of flow into the shortfall and then the effect of the delay in payments.

MR. GAFFNER: That would be a good point for us to let the planning board know; participation in the Medicaid program is voluntary and certainly a facility, and I know I hear a lot of -- I think, Gerry, you and I have talked about that -- a lot of discussion out there that the next generation or by that, I mean even within these next few years facilities that are built may be built totally for private pay even on the long-term care side just because of the financial liability that the Medicaid program creates.

MR. MORADO: That's what we have for our presentation on Medicaid. I think that, you know, when I get some finality to who is going to be presenting, I can work with that group, have maybe a smaller conversation and make sure that, you know, everybody knows their role in terms of what we're trying to say and/or present on these particular topics within the issue of Medicaid funding.

Is there anything that people think we're not touching on or haven't touched on that we need to touch on that should be included in this part of the conversation?

MR. LAVENDA: If you want new facilities built that do service the public aid population, you are going to have to adjust how they are being reimbursed. Right now it is at an extremely low level. Cost per bed is about 49,000 a bed and Gerry, you have built facilities in the last few years. You know it is a lot more than that.

MR. JENICH: Three times that.

MR. LAVENDA: Yeah.

MR. MORADO: All right. I think that goes to the heart of the mission of this board which is to ensure access to care. So I think that dovetails perfectly with our -- maybe that's a, maybe that is a recommendation that comes out of this, some sort of letter maybe from our board to HFS or to whomever saying that one of the ideas we would have is an adjustment to the reimbursement rate for facilities that are going to be servicing those who are on public aid.

MR. FOLEY: That's all dictated by legislature.

MR. MORADO: It certainly is, but I guess what I'm saying, Chuck, is that, you know, we go ahead and put this together, get it out from us,

you know, instead of just having -- I mean, the one off conversation is certainly helpful. I mean, everybody here, I think, has maybe taken part in some sort of lobbying at one point or another. We know the importance of that. But a collective voice, I think, also carries quite a bit of weight.

So I would hope that we are doing this entire exercise because we are trying to accomplish something, and if that's one of our recommendations, I think we should stand behind it.

MR. GAFFNER: Juan, I don't know if you are thinking in terms that there is what I call a Medicaid summary before either the planning board members ask questions, but I think we can make some very, some very justified assumptions that goes back to what John Florina was saying. We are now moving even more quickly to a two-tier delivery system in this state. There is private pay versus Medicaid, and when people think in terms of a building that seems to be older or maybe less fresh, less bright, has not been renovated in awhile, that could very well be and likely is -- Steve, you do those numbers all the time -- that's probably a facility that has 90 to 100% Medicaid

utilization. So the dollars aren't there to be able to have that facility look like a facility would that maybe had a 20 or 30% Medicaid utilization. So I think that is a real assumption that can be made.

I think another assumption is what I mentioned, that providers will make a conscious decision to build, but they will not submit to be part of the Medicaid program. They will just simply do it on a private pay basis.

MR. MORADO: Is it fair to say that this idea of a two-tier system would be maybe a good conclusion to our presentation after we talk about the delay and we have already talked about the shortfalls, that this is what is happening now; we are leaning toward this two-tier system? Then maybe that logically will, you know, lead us to this idea that perhaps there should be an adjustment so that we can get some parody within the system, you know, some equity so folks who are on public aid, there is some consideration for that.

MR. GAFFNER: I believe those are two fair assumptions. I don't want to speak for, you know,

the whole group.

MR. MORADO: I say it so I open it up for the group to comment on.

MR. GAFFNER: I sure do. I think those are very real world assumptions.

MR. FLORINA: This is Florina again. I can't argue with that. Taking it a step further, maybe giving you a little more information to work with in this regard, I want to relate it back to the competing care facilities within the continuum that we talked about earlier as far as how this two-tier system is evolving.

It is not just private pay versus Medicaid. It seems to be assisted living versus nursing home because the private pay are going to the assisted living if there is any way they can stay there, and the nursing home will be saddled with more Medicaid.

So in addition to losing patients in the nursing home side, and this is notwithstanding the fact that residents should be aware of their most appropriate care, but you are losing out on patients out of the nursing home side and being cherry picked by the assisted living side because

they are private pay. I'm sure if you had Medicaid system for assisted living, they'd want nothing to do with it because they are filling their beds with private pay.

The second aspect is the income that obviously is lost or derives from the type of payment you are receiving for your patients. The nursing homes are already in a funk, in a hole because of low reimbursement rates for Medicaid. It is just exacerbated because you are losing all of the private payers to another type of facility, and those private payers usually offset or help offset shortages in Medicaid. I don't mean to go back to 101 basics here with Medicaid, but from a provider's standpoint, that's the reality of what is happening.

MR. MORADO: Right.

MS. MITCHELL: I just want -- people are making very good points, and it seems like we are going to have a really good discussion before the board next month. I just want everyone to be mindful of how much time it will take to have that discussion. So I don't know, Juan can explain a little bit more about how much time will likely be

allotted for this, but we also want to leave time for a question and answer session with the board because that's probably going to take a lot of time also.

MR. MORADO: We have been limited to three hours.

MS. MITCHELL: You wish.

CHAIRMAN: I had to unmute it to go what are you talking about.

MR. MORADO: I am kidding. You know, I think that, I'm trying to think how long we went last time. I want to say 45 minutes to an hour. I think it depends how engaged the board is, right?

I think that they are going to have questions. I think that presentations could take anywhere from 10 to 15 minutes itself. I think these sorts of things tend to be more effective when there is a back and forth from the question and answer side because maybe things that we don't get to during the actual presentation will be much more fully flushed out during question and answer. It has just been my experience. I think it gets folks much more engaged.

I would say that -- Courtney will tell me

if I am wrong, conservatively we should try and look at 30 minutes, you know, 15 minute presentation, 15 minute question and answer, but, again, if the board wants to keep talking, the chair will certainly keep talking, and if she is ready to end the conversation, she will do it in the most polite manner as possible, I'm sure.

CHAIRMAN: This is Mike again. Based upon what happened the first time, we did get a lot of questions, and we did go, I think, longer than we had anticipated. So I think they're very interested, and they are out to learn. So I agree with you. You know, I think we should be prepared for X amount of time, 30 minutes, and then see what happens next. I think we are all good enough if they don't ask questions, we can continue moving with, you know, plan B in terms of our presentation.

MR. MORADO: Right. Okay.

MR. JENICH: Juan, just to comment. Given the amount of time, I'm just sitting here thinking that the agenda's too aggressive, too many items on it. We are going to have to pick one which raises another thought. These are the items we are

picking. Does it make any sense to independently have you guys survey the board, show them the items that we have and ask them if they have a preference over which one kind of goes first?

MR. MORADO: Yeah, we can certainly do something like that. I don't think that's an issue. Again, we will have to reach out to them on a more limited basis because of the Open Meetings Act restrictions, but we can certainly do something along those lines.

Now, when you say, when you say, "too aggressive", are you talking about the five different subjects?

MR. JENICH: The five different subjects, the time frame that we are given. Another thought to just looking at how you process or how a group processes like this, right, is maybe using first session to kind of outline all of the macro issues which are the items on the agenda and then kind of, maybe wrong term but right idea, right, baiting the board into having subsequent sessions where you are picking one of those topics to discuss at follow-up board meetings.

MR. MORADO: Well, I think fortunately for

us we do have a commitment now, and I think with her knowledge it would be more than a one off kind of thing. I think that she really, she enjoyed the conversation that you had during lunch and sees the benefit of this being a continuing thing.

To be quite honest, I have been with the board now about five years, and this has been a conversation that we have had not just about long-term care but about a number of different industries that come before the board whether it be ESRD, whether it be the idea of, you know, does 100-bed hospital make sense, just a number of different issues in the idea of continuing education because, as many folks know, we have quite a few new members now. But even for our members that have been on for awhile, making sure that they have an idea of what is happening in the industry instead of seeing it for the first time when an application is before them. I think that makes, makes a lot of sense.

We have been throwing around that idea. This is actually the first time it has really happened. We have been planning something like this for ESRD for years now, and as the

applications for that type of project have slowed down a bit from where they were at I would say five years ago, it has not been -- efforts to put that together has not been as intense as it has been for long-term care which is why we are where we are at right now.

MR. JENICH: Okay. Then one final question, right? There is a lot of experts on the long-term care advisory subcommittee. Everybody has got niches or specialties. But for some of the topics -- I'm just throwing it out again -- just does it make sense maybe to invite a third party in to do a presentation?

MR. MORADO: I think it does. I would say that as we flush out the other --

MR. JENICH: There is no bias.

MR. MORADO: As we flush out the other areas, we probably really want to consider that. I think that might be most, most prudent for assisted living or the survey, I guess, of the health care marketplace because, as Paul pointed out and as we kind of talked about a little bit here, there is going to be some opposition.

So I think it might make sense, and we can

kind of start to think about that now who would be a good person to kind of bring into that conversation and talk about from a third party perspective about the effects of these other types of facilities. I think that would make a lot of sense.

Medicaid I think it is probably okay that we are having just board members present on it, and I think that we have benefit of having Dr. Goyal, the medical director for the program, as a part of the board who the members themselves have a great deal of confidence in. So I think that, I think we are good there.

The other ideas that we talked about, you know, the 90% occupancy, the staffing shortages, those types of things, I think as we start to dig into them, we will figure out where it makes sense to bring in a third party. That's a great idea.

MR. JENICH: Okay. Thank you.

MS. MITCHELL: Even this subcommittee itself, I mean, there are differing viewpoints within the subcommittee. So I think it is important even, you know, everybody might not be available the days the education session is going

to happen, but those presenting express those differing viewpoints. I think it is their responsibility to do so. I think that's very important, too.

MR. MORADO: Okay. So with all that said, we are looking at June 20th for our presentation on Medicaid. I will have a call with the presenters between now and then, and we can talk about how we are going to actually present. As I gauge interest, see who is interested on being on that call or who actually is going to present, you know, please feel free to reach out to me directly. We can figure that out. I think that we probably want to meet again as a group after that presentation so we can dissect it and then plan for what the next one will be.

Is there an idea of -- well, I guess what I will do, I will take that idea that you had, Gerry, in terms of surveying the board and try to get a sense of what they would like to see, and I will send an email out in advance of the meeting to give folks a heads-up on which one we are going to start digging into next after we dissect the last conversation.

MR. JENICH: This works already been done on Medicaid, then it makes the most sense, I think, just --

MR. MORADO: Yeah. So we should look at July, then, for the next meeting because June 20th is already at the end of the month.

Is there -- Court, do you have any particular idea about when we should get together?

MS. AVERY: Nope, I do not.

MR. MORADO: We are not going to do the 4th. The 11th, second week of July? How do people feel about that?

UNIDENTIFIED: What day of the week?

MR. MORADO: Tuesday.

MR. FOLEY: That is fine with me.

UNIDENTIFIED: I can't do that.

MR. MORADO: The 18th? How is the 18th?

MR. FOLEY: The 18th is also fine.

MR. MORADO: We have got, I have got to make sure Paul is going to be here. Hold on.

MR. CORPSTEIN: No.

MS. MITCHELL: Shouldn't have said anything.

MR. MORADO: How about I look and see what

we have in terms of availability for rooms. 18th. Okay. I will look at 11 and 18 for now, and we will go from there.

Does anyone else have -- let's see, where are we at here? Other business, no. 7. Any other business?

MS. MITCHELL: If I may, we discussed, we have talked a couple of times about these amendments to the 1125 rules, and we presented them initially to the board in the March meeting, I believe. So the board initially approved those changes, and then we had Nelson, Nelson and everybody had additional discussions about the mileage that was determined then.

So went back to the board this month, and so the new mileage would be 10 miles for Chicago, 17 for metropolitan areas and 21 miles for everywhere else which is basically rural areas. Those rules I had hoped to have been (unintelligible) by now, and what is taking so long is there is predraft process with JCAR where we kind of made some technical changes and fine-tuned some things just so we could take, do the bulk of that on the front end.

As you know, this is not the only rule we are changing. It is not the only rule affected by this change. So some of the other rules that are affected require a little bit more work, and I don't want to file this rule out of turn. So we are waiting for everything to be done, but I am, I'm very confident that it will be done, it will be filed for first notice this month. So just wanted to provide an update on that.

MR. MORADO: All right. Now it is time to say good-bye.

MR. FOLEY: Motion to adjourn.

MR. MORADO: All right. Do we have a second?

MS. MITCHELL: Courtney has something.

MR. MORADO: Courtney, did you have something?

MS. AVERY: No, I'm fine.

MS. MITCHELL: Oh, okay.

MR. MORADO: Mr. Waxman, did you have something? I heard you talking.

CHAIRMAN: Yeah. Before we adjourn I want to simply thank everyone who did some work for the committee, thank everyone for joining us during the

conversation. They're all very -- I think that we represent different sides of expertise. So these meetings turn out to be very educational for me, I assume I'm hoping for all of the other members also. So again, just thank you all for taking time and staff for getting it together. Looking forward to the next step.

MR. MORADO: Great. Thank you. And we have a motion by Mr. Foley. Do we have a second?

MR. JENICH: Second.

MR. MORADO: Second by Mr. Jenich to adjourn. All those in favor?

(Ayes heard.)

MR. MORADO: The ayes have it. We are adjourned. Thank you.

(Hearing adjourned at 11:41 a.m.)

CERTIFICATE OF REPORTER

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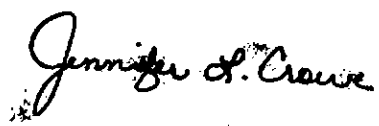

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